FY 2021 IPPS Final Rule Overview

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Overall Impact

- CMS estimates increases to the IPPS rates required by the statute, in conjunction with other payment changes in the final rule, result in an estimated $3.5 billion increase in FY 2021 payments (+2.5%), compared to the FY 2020 final rule. This increase is primarily driven from an additional $3.0 billion in IPPS operating and uncompensated care payments and $506 million in IPPS capital and new technology add-on payments.

Final Rule Changes by Hospital Type

Hospital Type	All Final Rule Changes
All Hospitals	2.5%
Urban	2.5%
Rural	2.2%
Non-Teaching	2.2%
100 or > Residents	2.7%
< 100 Residents	2.5%

IPPS Operating Payment Rates to Increase 2.9%

- The final rule will increase IPPS operating payment rates by 2.9% for hospitals that successfully report quality measures and are meaningful users of electronic health records (EHR).
- The 2.9% rate increase reflects the result of a projected hospital market basket update of 2.4%, and an adjustment of +0.5% required under the Medicare Access and CHIP Reauthorization Act (MACRA). There is no adjustment to the FY 2020 update for multifactor productivity (MFP). The payment rate update factors are summarized in the table below.

Factor	Percent Change
FY 2021 Market Basket	2.4%
MACRA Documentation and Coding Adjustment	+0.5%
Net increase before application of budget neutrality factors	2.9%

FY 2021 Final Rule Tables 1a-1c

	Standardized Operating Amounts Wage Index > 1		Standardized Operating Amounts Wage Index < 1	
	Labor	Non-Labor	Labor	Non-Labor
Submitted Quality Data and Is a Meaningful User (2.4% Update)	$4,071.49	$1,889.70	$3,695.94	$2,265.25
Did Not Submit Quality Data and Is a Meaningful User (1.8% Update)	$4,047.63	$1,878.63	$3,674.28	$2,251.98
Submitted Quality Data and Is Not a Meaningful User (0.6% Update)	$3,999.92	$1,856.48	$3,630.97	$2,225.43
Did Not Submit Quality Data and Is Not a Meaningful User (0% Update)	$3,976.06	$1,845.41	$3,609.31	$2,212.16
Puerto Rico	N/A	N/A	$3,695.94	$2,265.25

Note that the standardized amounts do not include the 2% Medicare sequester reduction that began in 2013.

Program and Policy Impacts on Payments

National Capital Rate: The final FY 2021 capital rate will be $466.22, a 0.84% increase over the FY 2020 rate of $462.33.

Outlier Threshold: CMS is adopting an outlier threshold for FY 2021 of $29,051. (compared to the FY 2020 final threshold of $26,552). CMS projects that the outlier threshold for FY 2021 will result in outlier payments equal to 5.11% of operating DRG payments and 5.363% of capital payments.

Hospital Value-Based Purchasing (HVBP) Program: The HVBP program is budget neutral, but will redistribute about $1.9 billion (2% of base operating MS-DRG payments) based on hospitals' performance scores.

Program and Policy Impacts on Payments

Medicare DSH: For FY 2021, CMS is updating its estimates of the three factors used to determine uncompensated care payments. The amount available to distribute as payments for uncompensated care for FY 2021 will decrease by approximately $60.5 million (.7%), as compared to its estimate of the uncompensated care payments that will be distributed in FY 2020.

Hospital Acquired Conditions (HAC) Reduction Program: CMS provides an analysis by hospital category of how hospitals are affected by the HAC reduction program. By law, the penalty applies to 25% of all hospitals or 777 of 3,111 non-Maryland hospitals with a HAC score. The reductions in payment is not budget neutral.

Program and Policy Impacts on Payments

Rural Community Hospital Demonstration Program: CMS is applying a budget neutrality adjustment for the Rural Community Hospital Demonstration Program based on $39.8 million in costs for FY 2021 for 22 hospitals.

Hospital Readmissions Reduction Program (HRRP): The HRRP will reduce FY 2021 payments to an estimated 2,545 hospitals or 85% of all hospitals. This reduction in payment is not budget neutral. The readmissions penalty will affect 0.68% of payments to the hospitals that are being penalized for excess readmissions. CMS estimates the program will save approximately $553 million in FY21.

Program and Policy Impacts on Payments

- **Documentation and Coding:** CMS continues a six-year add-back related to prior year documentation and coding reductions by increasing operating payments by .5% for FY 2021. Absent changes in legislation, this increase will continue annually through FY 2023.

- **New Technology Add-On Payment (NTAP):** CMS is discontinuing NTAP payments for 8 new technologies, continuing payments for 10, and approving NTAP payments for an additional 14 new technologies. Of these 14 new technologies, 8 are automatically deemed to have met the substantial clinical improvement criterion as a breakthrough technology or qualified infectious disease product. In total, 24 technologies are eligible to receive add-on payments for FY 2021. CMS estimates that costs for new technologies receiving NTAP for the first time in FY 2021 will be $665.756 million. This increase in payments is not budget neutral.

Program and Policy Impacts on Payments

New MS-DRG for Chimeric Antigen Receptor (CAR) T-cell Therapy: The final rule creates a new MS-DRG 018 specifically for cases involving CAR T-cell therapies. The new payment group helps to predictably compensate hospitals paid under the IPPS for their costs in delivering necessary care to Medicare beneficiaries and provides payment flexibility for the future as new CAR T-cell therapies become available.

Indirect Medical Education (IME) Adjustment Factor: For discharges occurring during FY 2021, the formula multiplier is 1.35.

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Post-Acute Care (PAC) Transfer Policy

- Final PAC transfer policy list for FY 2021.

List of Final New or Revised MS-DRGs Subject to Review of Post-Acute Care Transfer Policy Status for 2021

New or Revised MS-DRGs	MS-DRG Title	Current Postacute Care Transfer Policy Status	Proposed Postacute Care Transfer Policy Status
16	Autologous Bone Marrow Transplant with CC/MCC	No	No
18	Chimeric Antigen Receptor (CAR) T-Cell Immunotherapy	New	No
19	Simultaneous Pancreas and Kidney Transplant with Hemodialysis	New	No
140	Major Head and NeckProcedures with MCC	New	No
141	MajorHead and Neck Procedures with CC	New	No
142	Major Head and Neck Procedures without CC/MC	New	No
143	Other Ear, Nose, Mouth and Throat O.R. Procedures with MCC	New	No
144	Other Ear, Nose, Mouth and Throat O.R. Procedures with CC	New	No
145	Other Ear, Nose, Mouth and Throat O.R. Procedures without CC/MCC	New	No
469	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC or Total	Yes	Yes
470	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC	Yes	Yes
521	Hip Replacement with Principal Diagnosis of Hip Fracture with MCC	New	Yes
522	Hip Replacement with Principal Diagnosis of Hip Fracture without MCC	New	Yes
650	Kidney Transplant with Hemodialysis with MCC	New	No
651	Kidney Transplant with Hemodialysis without MCC	New	No
652	Kidney Transplant	No	No

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Special Payment Policy

- Final list of MS–DRGs subject to the special payment policy methodology for FY21.

List of Final New or Revised MS-DRGs Subject to Review of Special Payment Policy Status for FY21

Revised MS-DRG	MS-DRG Title	Current Special Payment Policy Status	Special Payment Policy Status
469	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC or Total	Yes	Yes
470	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC	Yes	Yes
521	Hip Replacement with Principal Diagnosis of Hip Fracture with MCC	New	Yes
522	Hip Replacement with Principal Diagnosis of Hip Fracture without MCC	New	Yes

Inpatient Quality Reporting Program

- Under the Inpatient Quality Reporting Program (IQR) for FY 2023 (reporting period of CY 2021) hospitals must submit data for four self-selected electronic clinical quality measures (eCQMs) chosen from a list of nine.

- Beginning with FY 2024 payment (CY 2022 reporting), hospitals are to report four measures: three are to be chosen by the hospital from among a list of eight possible eCQMs, and the fourth must be reported by all hospitals:

    - The Safe Use of Opioids – Concurrent Prescribing eCQM

Medicare Bad Debt : Non-Indigent Beneficiaries

- The final rule clarifies/defines the following related to Medicare allowable bad debt:

- ***Non-Indigent Beneficiary*****:** A non-indigent beneficiary is a beneficiary who has not been determined to be categorically or medically needy by a State Medicaid Agency to receive medical assistance from Medicaid, nor have they been determined to be indigent by the provider for Medicare bad debt purposes. To be considered a reasonable collection effort for non-indigent beneficiaries, all of the following are applicable:

Medicare Bad Debt: Non-Indigent Beneficiaries

- A provider's collection effort, or the effort of a collection agency acting on the provider's behalf, or both, to collect Medicare deductible or coinsurance amounts from *non-indigent beneficiaries* must consist of all of the following:
    - Be similar to the collection effort put forth to collect comparable amounts from non-Medicare patients.
    - For cost reporting periods beginning before October 1, 2020, involve the issuance of a bill to the beneficiary or the party responsible for the beneficiary's personal financial obligations on or shortly after discharge or death of the beneficiary.
    - For cost reporting periods beginning on or after October 1, 2020, involve the issuance of a bill to the beneficiary (or the party responsible for the beneficiary's personal financial obligations) on or before 120 days after the latter of one of the following:
        - The date of the Medicare remittance advice that results from processing the claim for services furnished to the beneficiary and generates the beneficiary's cost sharing amounts
        - The date of the remittance advice from the beneficiary's secondary payer, if any
        - The date of the notification that the beneficiary's secondary payer does not cover the service furnished to the beneficiary

Medicare Bad Debt: Non-Indigent Beneficiaries

- A provider's collection effort, or the effort of a collection agency acting on the provider's behalf, or both, to collect Medicare deductible or coinsurance amounts from *non-indigent beneficiaries* must consist of all of the following:
  - Include other actions such as subsequent billings, collection letters, and telephone calls, emails, text messages or personal contacts with this party
  - Last at least 120 days after paragraph from the initial bill before being written off as uncollectible
  - Start a new 120-day collection period each time a payment is received within a 120-day collection period
  - Maintaining and, upon request, furnishing verifiable documentation to its contractor that includes all of the following:
  - The beneficiary's file with copies of the bill(s) and follow-up notices
  - The provider's bad debt collection policy which describes the collection process for Medicare and non-Medicare patients
  - The patient account history documents which show the dates of various collection actions such as the issuance of bills to the beneficiary, follow-up collection letters, reports of telephone calls and personal contact, etc.

Medicare Bad Debt: Indigent Beneficiaries

- ***Reasonable Collection Effort, Beneficiaries Determined Indigent by Provider Using Required Criteria:*** A provider must apply its customary methods for determining whether the beneficiary is indigent under the following requirements:
  - The beneficiary's indigence must be determined by the provider; a beneficiary's signed declaration of indigence is not sufficient.
  - The provider must take into account the analysis of both the beneficiary's assets (only those convertible to cash and unnecessary for the beneficiary's daily living) and income.
  - The provider may consider extenuating circumstances that would affect the determination of the beneficiary's indigence or medical indigence which may include an analysis of both the beneficiary's liabilities and expenses, if indigence is unable to be determined using an income and convertible asset test.
  - The provider must determine that no source other than the beneficiary would be legally responsible for the beneficiary's medical bill.
  - Once indigence is determined, the bad debt may be deemed uncollectible without applying the "reasonable collection effort" described above.

Medicare Bad Debt: Dual Eligible Beneficiaries

- ***Reasonable Collection Effort, Dual Eligible Beneficiaries and the Medicaid Remittance Advice:*** The provider must submit a bill to the state Medicaid program to determine the state's cost-sharing obligation to pay all, or a portion of, the applicable Medicare deductible and coinsurance. The provider must then submit to its contractor a Medicaid remit reflecting the state's payment decision. Any amount that the state is obligated to pay, either by statute or under the terms of its approved Medicaid state plan, will not be included as an allowable Medicare bad debt, regardless of whether the state actually pays its obligated amount to the provider.

Medicare Bad Debt: Dual Eligible Beneficiaries

When, through no fault of the provider, a provider does not receive a Medicaid remittance advice because the state does not permit a Medicare provider's Medicaid enrollment for the purposes of processing a beneficiary's claim, or because the state does not generate a Medicaid remittance advice, the provider:

- Must submit to its contractor, all of the following auditable and verifiable documentation:
  - The state's Medicaid notification, stating that the state has no legal obligation to pay the provider for the beneficiary's Medicare cost sharing.
  - A calculation of the amount the state owes the provider for Medicare cost sharing Verification of the beneficiary's eligibility for Medicaid for the date of service.
- Must reduce allowable Medicare bad debt by any amount the state is obligated to pay, regardless of whether the state actually pays its obligated amount to the provider.
- May include the Medicare deductible or coinsurance amount, or any portion thereof that the state is not obligated to pay, and which remains unpaid by the beneficiary, as an allowable Medicare bad debt.

IPPS Final Rule: Topic 606

The final rule also addresses Financial Accounting Standards Board's Topic 606, related to revenue recognition from contracts with customers.

Cost Report Periods Beginning Before: 10/1/20	Cost Report Periods Beginning on or After: 10/1/20
• Bad debt and charity represent reductions in revenue. • Medicare bad debts must not be written off to a contractual allowance account but must be charged to an expense account for uncollectible accounts (crossovers)	• Charity & courtesy allowances represent reductions in revenue • Medicare bad debts must not be written off to a contractual allowance account but must be charged to uncollectible receivables account that results in a reduction of revenue (crossovers)

Source: BKD, Medicare Regulatory Update - What's New for FFY 2021?, October 28,2020

Inpatient Quality Reporting Program

- The rule finalizes changes to the hospital reporting of eCQMs, including progressively increasing the number of quarters of eCQM data reported, from one self-selected quarter of data to four quarters of data over a three-year period:
    - For FY23 payment (CY21 reporting) hospitals must report data for 2 self-selected calendar quarters;
    - For FY24 payment (CY22 reporting) hospitals must report data for 3 self-selected calendar quarters;
    - For FY 2025 payment (CY23 reporting) and subsequent years, hospitals must report data for all 4 calendar quarters.

Inpatient Quality Reporting Program

- The IQR Program includes one measure that is calculated using a hybrid of claims data and data reported by the hospital through EHR Technology: The Hybrid Hospital-Wide Readmission (HWR) measure.
  - Will be open for reporting in two voluntary reporting periods (July 1, 2021, through June 30, 2022, and July 1, 2022, through June 30, 2023)
  - Will be a mandatory measure beginning with the FY26 payment determination
- For purposes of reporting this measure, hospitals must use EHR technology certified to the 2015 Edition for CEHRT and submit the required data elements using the QRDA I file format.
- CMS finalizes its proposals to combine the validation processes for chart-abstracted and eCQM data over time.

Inpatient Quality Reporting Program

- Only one clinical process of care measure subject to chart-abstracted data validation (the sepsis measure) remains in the IQR Program for the 2021 reporting period (FY 2023 payment).

- CMS finalizes proposals to streamline the validation processes under the Hospital IQR Program. The proposal include:

1. Updating the quarters of data required for validation for both chart-abstracted measures and eCQMs
2. Expanding targeting criteria to include hospital selection for eCQM
3. Changing the validation pool from 800 hospitals to 400 hospitals
4. Removing the current exclusions for eCQM validation selection
5. Requiring electronic file submissions for chart-abstracted measure data
6. Aligning the eCQM and chart-abstracted measure scoring processes
7. Updating the educational review process to address eCQM validation results

Inpatient Quality Reporting Program

- CMS finalizes that public reporting of eCQM data will begin with data reported in 2021 for the FY 2023 payment determination.
- These data will be posted in a downloadable data set on the https://data.medicare.gov/ web page.
- CMS notes that this data will then be published on the Hospital Compare or successor website “sometime in the future.”

Promoting Interoperability

- Hospitals not identified as meaningful users of CEHRT under the Medicare Promoting Interoperability Program are subject to an update factor reduction equal to three quarters of the market basket.

- As part of being a meaningful user under the Medicare and Medicaid Promoting Interoperability Programs, eligible hospitals and CAHs must report on eCQMs selected by CMS.

- An EHR reporting period is finalized as a minimum of any continuous 90-day period in CY 2022 for new and returning participants (eligible hospitals and CAHs) in the Medicare Promoting Interoperability Program attesting to CMS.

- “Query of Prescription Drug Monitoring Program” is measure continued as an optional measure worth 5 bonus points in CY 2021.

Promoting Interoperability

- “Support Electronic Referral Loops by Receiving and Incorporating Health Information” measure renamed the “Support Electronic Referral Loops by Receiving and Reconciling Health Information” measure.

- Final rule progressively increases the number of quarters for which hospitals are required to report eCQM data, from the current requirement of one self-selected calendar quarter of data, to four calendar quarters of data, over a three-year period.

2021 eCQMs

- The 8 eCQMs available for 2021 reporting:

CQMs for Eligible Hospitals and CAHs for CY 2021 and Subsequent Years

Short Name	Measure Name	NQF No.
ED-2	Admit Decision Time to ED Departure Time for Admitted Patients (ED-2)	0497
PC-05	Exclusive Breast Milk Feeding	0480
STK-02	Discharged on Antithrombotic Therapy	0435
STK-03	Anticoagulation Therapy for Atrial Fibrillation/Flutter	0436
STK-05	Antithrombotic Therapy by the End of Hospital Day Two	0438
STK-06	Discharged on Statin Medication	0439
VTE-1	Venous Thromboembolism Prophylaxis	0371
VTE-2	Intensive Care Unit Venous Thromboembolism Prophylaxis	0372
Safe Use of Opioids	Safe Use of Opioids – Concurrent Prescribing	3316e

- The Safe Use of Opioids measure was also finalized as a mandatory measure beginning with the 2022 reporting period. At that time, eligible hospitals and CAHs must report that measure and three others selected from among the eight.

Promoting Interoperability

- Under the final rule, this requirement is progressively increased to four quarters of data as follows:
  - Two self-selected calendar quarters of data for the CY21 reporting period
  - Three self-selected calendar quarters of data for the CY22 reporting period
  - Four calendar quarters of data beginning with the CY23 reporting period
- The submission period for the Medicare Promoting Interoperability Program will be the two months following the close of the respective calendar year.
- eCQM performance must be publicly reported beginning with the eCQM data reported by eligible hospitals and CAHs for the reporting period in CY 2021 on the Hospital Compare and/or data.medicare.gov websites or successor websites.

Hospital-Acquired Conditions Reduction Program

- The 1% payment reduction applies to hospitals that rank in the worst-performing quartile (25%) of all applicable hospitals, relative to the national average, of conditions acquired during the applicable period and on all of the hospital's discharges for the specified fiscal year.

- CMS finalizes the following policies to:

  - Automatically adopt applicable periods beginning with the FY23 program year and all subsequent program years, unless otherwise specified by the Secretary;
  - Refine the process for validation of HAC Reduction Program measure data in alignment with the Hospital Inpatient Quality Reporting (IQR) Program measure validation policies finalized in the rule;
  - Update the definition of applicable period to align with the policy to automatically adopt applicable periods.

Hospital-Acquired Conditions Reduction Program

- CMS finalizes automatic adoption of applicable periods beginning with FY 2023, and changes to data validation procedures. No changes are made to program measures, data collection processes, scoring methodology, or other program policies.

- Beginning in FY 2023, the applicable period for both the CMS PSI 90 and CDC NHSN HAI measures will be the 24-month period beginning 1 year after the start of the applicable period for the previous program year.

    - For FY 2023, the applicable period for the CMS PSI 90 measure is the 24-month period from July 1, 2019, through June 30, 2021.

    - The applicable period for CDC NHSN HAI measure is the 24-month period from January 1, 2020, through December 31, 2021.

Disproportionate Share Hospital Updates

- The Office of the Chief Actuary has updated its projection of the rate of uninsurance for purposes of calculating the final Factor 2 for FY 2021 given the unprecedent impact of the COVID-19 PHE and more recent available data regarding levels of uninsurance.

- Based on these data, CMS updates its rate of uninsurance to 10.3% for FY 2020 and 10.2% for FY 2021 (up from 9.5% used in the proposed rule for both years).

    - This results in an uncompensated care amount for FY 2021 that is closer to FY 2020 levels than the proposed rule estimate.

- CMS now projects that the amount available to distribute as payments for uncompensated care for FY 2021 would decrease by approximately $60.5 million, as compared with its estimate of the uncompensated care payments that will be distributed in FY 2020.

Disproportionate Share Hospital Updates

- Projected 2021 DSH spending in the final rule ($15.171B) is approximately 8.5% lower than DSH spending ($16.583) in the 2020 final rule.

- Updating the uninsured rate in the final rule to account for the economic dislocation caused by the COVID-19 pandemic increased uncompensated care (UC) DSH payments available for allocation by $473 million, or approximately 6% compared with the proposed rule.

- For FY 2021, CMS will use a single year of UC data from audited worksheet S-10 data from the FY17 cost report for most hospitals to calculate Factor 3.

    - Data selected by CMS because 65% of the proposed UC payments have been subjected to audits.

Disproportionate Share Hospital Updates

- CMS will also continue to:
  - Use data regarding low-income insured days (Medicaid days for FY13 and FY18 Supplemental Security Income days) to determine the amount of UC payments for Puerto Rico hospitals and Indian Health Service and Tribal hospitals for one more year (FY21)
  - Use a proxy for SSI days for Puerto Rico hospitals, consisting of 14% of a hospital's Medicaid days, as finalized in the 2017 IPPS/LTCH PPS final rule.

Hospital Readmissions Reduction Program

- CMS finalizes automatic adoption of applicable periods beginning with FY 2023.

- Consistent with previously adopted periods, the applicable period for the HRRP will be the 3-year period beginning one year advanced from the start of the applicable period for the previous program fiscal year.

  - That is, for FY 2023, the applicable period for HRRP measures and for determining dual eligibility is the 3-year period from July 1, 2018, through June 30, 2021.

- No changes are made to the HRRP measures, the methodology for calculating the payment adjustment, or other program features.

Hospital Readmissions Reduction Program

- As promised in the FY 2020 IPPS/LTCH final rule, CMS indicates that it included data on the six readmissions measures stratified by patient dual eligible status in the confidential hospital-specific reports provided to hospitals in the spring of 2020.
- For FY 2021, CMS will use the same methodology for calculating aggregate payments for the excess readmissions portion of the HRRP formula, which includes using the March update of the fiscal year MedPAR data corresponding to the applicable period.
- The conditions covered in the HRRP include acute myocardial infarction (AMI); heart failure (HF); pneumonia (PN); elective total hip arthroplasty (THA)/total knee arthroplasty (TKA); chronic obstructive pulmonary disease (COPD); and coronary artery bypass graft surgery (CABG).

New Technology Add-on Payments

- Beginning with FY 2022, new technology add-on payments for all applicants and previously approved technologies that may continue to these payments, CMS will use the proposed threshold for a proposed new MS-DRG for the upcoming fiscal year to evaluate the cost criterion for technologies that would be assigned to a proposed new MS-DRG.
- For FY 2021, CMS finalizes its proposal to discontinue 8 new technology add-on payments for:
  - KYMRIAH™ and YESCARTA®, VYXEOS™, VABOMERE™, the remedē®System, Giapreza™, the Sentinel® Cerebral Protection System, the AQUABEAM System, and ERLEADA.
- CMS will continue 10 new technology add-on payments for:
  - ZEMDRI™, AndexXa™, AZEDRA®, CABLIVI®, ELZONRIS™, Balversa™, SPRAVATO™, XOSPATA®, JAKAFI™, T2Bacteria® Panel.
- CMS approved 14 items for new technology payments:
  - ContaCT, Eluvia™ Drug-Eluting Vascular Stent System, Hemospray® Endoscopic Hemostat, IMFINZI® and TECENTRIC®, Soliris, SpineJack® System, BAROSTIM NEO®, The Optimizer® System, Cefiderocol, CONTEPO™, NUZYRA®, RECARBRIO™, XENLETA, and ZERBAXA®.

MS-DRG Weight Setting

- For cost reporting periods ending on or after January 1, 2021, hospitals required to report on the Medicare cost report the median payer-specific negotiated charge that it has negotiated with all of its Medicare Advantage organization payers, by MS-DRG.
    - The requirement applies to subsection (d) hospitals in the United States and Puerto Rico.
- Payer-specific negotiated charges used to calculate these medians are the payer-specific negotiated charges for service packages that hospitals are required to make public under the requirements in the Hospital Price Transparency Final Rule that can be crosswalked to an MS-DRG.

MS-DRG Weight Setting

- Beginning in FY 2024, CMS will use the median payer-specific negotiated charge information for MA plans, collected on the cost report, to calculate MS-DRG relative weights.

- CMS not finalizing a transition period in the rule for the new MS-DRG weights based on median MA rates.

  - May reconsider the need for a transition period in a future rule.

- CMS will continue to produce a charge- based weight schedule for “several years” after it moves to market-based weights for MS-DRG payment

- Requirement that hospitals also report their median third-party payer rates in cost reports filed on or after January 1, 2021, not finalized.

Wage Index

- For FY 2021, CMS continues the low wage index hospital policy finalized in FY 2020. This policy will continue to be applied in a budget-neutral manner by proposing an adjustment to the standardized amounts.

- This is the second year (of at least four years) that this policy will be in effect to allow employee compensation increases implemented by these hospitals sufficient time to be reflected in the wage index calculation.

    - For the FY 2021 wage index, CMS refers readers to the FY 2020 final rule where it restated the steps published in the FY 2012 methodology updated for current references and technical changes.

Long-Term Care Hospital (LTCH) Payment Updates

- The LTCH updates for FY 2021 is as follows:

Factor	Full Update	Reduced Update for Not Submitting Quality Data
LTCH Market Basket	2.3%	2.3%
Multifactor Productivity	0.0 PP	0.0 PP
Quality Data Adjustment	0.0	-2.0 PP
Total	2.3%	0.3%

Long-Term Care Hospital (LTCH) Payment Updates

- The final rule increases the standard federal rate by 2.3%, or $43,755.34 for LTCHs that submit quality data.
    - Calculated as follows: $42,677.64 (FY 2020 payment rate) * 1.023 (statutory update factor) * 1.0016837 (area wage budget neutrality factor) * 1.000517 (25% threshold budget neutrality factor) = $43,755.34
- The reduced rate, for those that don't submit quality data is $42,899.90 (0.3% increase).
    - Calculated as follows: $42,677.64 (FY 2020 payment rate) * 1.003 (statutory update factor less quality adjustment) * 1.0016837 (area wage budget neutrality factor) * 1.000517 (25% threshold budget neutrality factor) = $42,899.90
- CMS expects LTCH PPS payments to decrease by approximately $40 million, which reflects the continued statutory implementation of the revised LTCH PPS payment system.

For More Information

- Read an executive summary of the final rule.
- Read a detailed summary of the final rule.
- Read the final rule, published in the September 18, 2020, *Federal Register*.

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